Goals and Benchmarks Workgroup
Meeting Minutes: 12/7/07

Documents Provided: Agenda, MFP budget, Benchmark #2 report, Barriers report from advocacy groups, MFP OP review criteria, NH Goals and Benchmarks OP, Diversion and Transition Services in the US (Promising Practices and Options for the Future), Long-Term Services and Supports: The Future Role and Challenges for Medicaid, DRA and HCBS: Opportunities for Rebalancing, Key Building Blocks in Designing a System in Which Money Can Follow the Person

Present: Doug Wegh, Hettinger County Social Services, Linda Wurtz, AARP, Bruce Murray, ND Protection and Advocacy, Bob Puyear-Bismarck, Shelly Peterson, ND Long Term Care Association, Linda Wright, ND Dept of Human Services, Aging Services Division, Royce Schultze, Dakota Center for Independent Living, Karen Tescher, Dept of Humans Services, Medical Services, Jake Reuter, DHS, Money Follows the Person Grant Program Manager, Carole Watrel, Bismarck, Gloria Glasgow, Ward County Social Services

1. Committee member introductions competed
2. Agenda finalized
3. Goal and Benchmark operational protocol requirements were reviewed including the need to address North Dakota's:

MFP Program's overall Mission and Purpose
State Objects for each of the 4 Statutory Objectives
-Rebalancing: Increase use of HCBS
-Eliminate barriers that prevent/restrict flexible use of Medicaid funds for Long Term Care in Home and Community Based Services
-Assure continued provision of HCBS after 1-year transition period
-Assure at least the same level of QA for MFP participants as available to other HCBS beneficiaries

How will the ND MFP grant:
-Further and/or complement ND's rebalancing efforts
-Strengthen previous or existing rebalancing and institutional transitioning program initiatives
-Communicate how the transition program and/or enhanced Federal Medical Assistance - Participation will be used to permanently rebalance the LTC system towards HCBS

Review of Benchmarks:

Two Required Benchmarks:
Projected Number of eligible individuals in each Target group
Qualified expenditures for HCBS during each year of the demonstration

Three additional benchmarks:
Development of the Aging and Disabilities Resource Center (ADRC)

Development of Stakeholder Group
Creation of a crisis intervention/response team

4. Mission/Purposes:

Karen Tescher, discussed that the MFP grant application was made to provide increased opportunity for persons residing in an institution to transition into the community and to Identify the gaps in service that prevent moves into the community. Individuals living in Nursing Facilities and ICF/MRs were the populations selected to be served by the grant.

5. Mission/Goals:
   - Develop a process to assist individuals with moving out of institutions and to assure that the get the care that they need
   - Develop services that "fill the gaps" in the service delivery system
   - Provide services to those persons that would not have naturally moved out of the nursing home-Currently about 1100 persons move from the NF back to the community each year or 1 in 4 move to a lower level of care

-MDS document notes individuals that want to return home
- Length of stay in NF has significant impact on the ability to return to community living-The longer the stay the more difficult it is to return home
- Discharge planning team will need to work very closely with the MFP transitioning team -
-Individuals that desire to go home will be referred to the MFP Transitional Coordinator (CIL)
-Nursing facility staff will refer individuals to CILs for transition assistance even if they are not MFP eligible

- Transitioning process will identify gaps, address service needs to address gaps, and develop services that will be used by all populations in need of services-Not just persons from ICF/MRs and NFs
- Education is needed related to:

-Financial planning to meet Long Term Care needs
>People that do plan ahead usually spend all of their savings on NF
>People are living longer
>Population of ND is aging
>Need to build system that that services people

-Community services available in the Home
>How many people really know what services are available?
>How many people know how to get services?
>People have a difficult time asking for assistance
>Getting in-home assistance earlier would delay nursing
Home placement-Most responsible action and would
Minimize use of public services
-Hospital discharge planners- need more education about available community services

-Education would help people plan, Improve attitudes about becoming involved with services,
-Why are we not getting to/reaching people now?

>senior citizen centers are not “full” anymore
>hospital discharge planners face “time pressure” and have difficult time arranging for community services, ramps, bathroom accommodations etc.
>Informal care giver survey noted majority of nursing home admissions have not received services prior to admission
>Hospital stays are getting shorter-Shorter discharge planning time
6. Barriers/Gaps

Opposition by family members
>Fear of their family member failing in the community
>Concerns about family member not being able to get back into the nursing home if they are not successful in the community
>Large cities do not have the frequent openings if someone would need to return-would likely have to move to a NF in a surrounding community.
>More frequent hospitalization tends to occur for individuals living in the community-Higher utilization of services by HCBS recipients
>Some HCBS recipients are barely able to maintain in the community
>Concern about risk-Need to minimize risk as much as possible
>Would need to refer to P/A or Ombudsman Office for assistance to assure that individual has opportunity for an informed decision
>May need to assume family will not be part of the natural support system
Centers for Independent Living staffing levels and limited coverage
>Pre-transition payment for services concerns under MFP-No payment for services if person does not move
Housing-accessible, affordable, available choices
>Assisted living is not paid an option at this time-no way to pay for the costs at this time (Bethany towers as rent subsidized AL)
>Rent vouchers normally require long wait
>Low income housing is more available sometimes in rural areas
>Rural development is working on more assessable housing
Current payment/funding source system based instead of person/needs based process
Non-medical transportation
Medically needy Limit of $500 make living in the community very difficult to afford even with food stamp, fuel assistance, and rental assistance
Limited community activity-Concerns about isolation
Family Foster Care-Intent is for family to bring someone into their home to provide care-Do not have to own home just have to leave in the home.

BARRIERS IN LAWS, RULES, POLICIES Identified by ADVOCACY GROUPS in April 2007

Only the counties provide case management or authorize services in North Dakota at this time. Others can provide these services if they meet the necessary qualification requirements. The reimbursement for case management services is of concern as many counties are providing additional funding to provide Case Management

This may make it difficult to be able to have an efficacious single point of entry system.

Exempt HCBS providers from equalized rates. (FEDERAL QUESTION) If a home service provider is contacted by someone who lives in a very rural area, and that client would like to pay mileage to have services in their home, it couldn't be done because they are not allowed to charge private pay more than public pay clients.

Home service workers often turn down a client who lives 20 or 30 miles away because they don't get reimbursed for mileage or drive-time. QSP cannot bill for mileage as they are suppose to build mileage into their rates

3. Remove the caps on HCBS. If individuals can only receive services that total less than 960 units per month, it forces them into institutional care. The cap should be the same level as institutional care.

4. We should review the statutes regarding nursing home rates. (NDCC 50-24.4) There is no way to replicate incentive payment for 90% occupancy in the HCBS arena; dividing the allowable historical operating costs by the actual number of resident days (NDCC 50-24.4-10(4) forces the state to pay the overhead for unoccupied beds. Under the funding formula, the State pays overhead to nursing homes for unoccupied beds. There should be a comparable payment for HCBS providers.

5. Address barriers to receiving services in assisted living.

6. Start promoting some of the statutes that would provide stimulation toward meeting Olmstead. Examples:

> **50-24.3-01. Targeted case management.** The department of human services shall establish a targeted case management service for disabled and elderly individuals eligible for benefits under chapter 50-24.1 who are at risk of requiring long-term care services to ensure that an individual is informed of alternatives available to address the individual's long-term care needs.

Funding is limited to Medicaid only individuals

50-24.3-03(5) to identify available non-institutional services to meet the needs of referred individuals.

50-24.3-03(7)

7. To inform referred individuals of the extent to which long-term care services are available, including institutional and community-based services, and of the individual's opportunity to choose, in consultation with an attending physician, family members, and other interested parties, among the appropriate alternatives that may be available.

26.1-45-04.1. Adoption of long-term care benefits comparison guides by commissioner. The insurance commissioner shall adopt rules to create a long-term care benefits comparison guide to be presented at the point of sale between the client and insurance producer. The guide must include information regarding nursing home coverage and alternatives to nursing home coverage.

23-01.1-02. Powers of health care data committee. To provide information to the public necessary for the enhancement of price competition in the health care market, the health care data committee may:

1. Collect, store, analyze, and provide health care data.
2. Compile the average aggregate charges by diagnosis for the twenty-five most common diagnoses, annual operating costs, revenues, capital expenditures, and utilization for each nonfederal acute care hospital in this state, and the average charges by source of payment and level of service in each long-term care facility in this state.
3. Establish a uniform format for the collection of information on charges to patients.
4. Prepare an annual report comparing the cost of hospitalization by diagnosis in each nonfederal acute care hospital and comparing average charges by source of payment and by level of service in each long-term care facility in the state.
5. Establish procedures that assure public availability of the information required to make informed health care purchasing decisions.

7. During 2006, DHS established, in administrative code, a cap on personal care services (120 – limited personal care services; 240 – individual is screened eligible for NF or ICF/MR). Institutions do not have a cap on the number of hours provided. The code does not allow for the cap to be waived. The same could be said for an individual looking to get out of an institutional setting. Caps should be eliminated. Money should follow the person.

10. Rate equalization payment method that is in place for nursing facilities. This was established in 1990 and continues to be supported by the NDLTCA.

11. There is continued bias toward institutional care. Institutional care is still a mandated service under Medicaid. Home & community-based services are still optional services. While they are provided in N.D., they are the "alternative". This is based on Federal rules

13. Consider Amends to our State Plan to require and document that before a person can be institutionalized, they must be offered HCBS first.

14. Congress now permits states to set "more stringent" needs-based criteria for NF placements than for HCBS. It maybe more effective to address eligibility for HCBS under the State Plan to allow individuals to receive services earlier. This is allowed by the DRA
15. Congress has mandated independent evaluations and assessments for persons who request HCBS to determine what the person requires. Congress wanted independent evaluations and assessments to prevent "unnecessary or inappropriate care" in the community, but has never required such for institutional care. If this is the case, shouldn't we be asking for independent evaluations and assessments BEFORE persons are placed into NF's? This would provide for more equality and unnecessary institutionalization.
THE current SPED program needs thresholds limit services for those that could use the service. Consider for change
16. Independent evaluations and assessments should require the consideration of assistive technology that might help the individual to live more independently.
17. There are less restrictive options for treatment of mental illness than a large institution (NDSH). While it may be barrier that the NDSH is in the State Constitution, options should be explored. Smaller regional or community facilities would be more appropriate and, most likely, eligible to receive Medicaid funds which would save the State money.
18. DHS has a bureaucratic policy that defaults to institutionalization. DHS needs a policy that allows an individual to select HCBS over institutionalization when the individual's physician confirms that the choice is reasonable. DHS should not force individuals to follow the most conservative approach to treatment. There must be room for well-informed, competent, voluntary medical choices.
19. The DHS Plan to Transfer Appropriate Developmental Center Residents to Communities – Report to the Legislative Council includes a recommended action step that requires: "Review and amend where appropriate administrative rules that are a disincentive for Independent Supported Living Arrangement placements." This apparently is recognition that administrative rules are a disincentive for ISLA placements but does not identify any specific rules.
20. The DHS website is not up-to-date for individuals who want to find information online. For example, DHS has a webpage "Publications: Services for People with Disabilities;" it includes links to three Olmstead documents, the newest of which is dated November 2002. The page also links to an undated "Students with disabilities who are transitioning from high school to a job in the community." There needs to be something identifying treatment options, community-based services, residential options, and a balanced description of each. There could be a chart comparing services, regimentation, social opportunities, dining, costs, Medicaid coverage, and flexibility. It should identify places to get more information.
22. Competitive wages for direct support staff in all HCBS services and community DD services are essential for HCBS/DD services to succeed and flourish.
23. Current policies provide too few employment opportunities for people with developmental disabilities. Meaningful employment is a key to self-esteem and successful living
24. NDCC 25-01.2(02) entitles people with developmental disabilities to "appropriate treatment, services, and habilitation … in least restrictive appropriate setting".

DHS policy has restricted this to include only those individuals who are eligible for the waiver under Medicaid. Many individuals with DD, who are not MR, are precluded from receiving needed services.

25. "In accordance with [NDAC], when a caretaker is enrolled as a [QSP], respite services can not be used when the caretaker chooses to be absent from the home due to employment". This was the response to the following situation:

A 94year-old woman, living in her own home, has lost both of her legs and is dependent on her daughter for care. The daughter gets paid by the State for taking care of her mother. The daughter is not yet old enough to qualify for Medicare so she works 2 days/week to get health insurance coverage for herself. On those 2 days, the State will not pay for a caretaker. The family cannot afford to pay for a caretaker themselves. There are no other family members in the immediate area that can help so a daughter drives over 200 miles, each way, to provide this care 2 days/week.

This was discussed as an issue that would need to be referred to family home care as they would allow for a higher payment. The state would consider this a "double dipping" situation at this time.

6. Dispute Resolution Options

CAP-provides CIL this service

DHS Appeals for all DHS related services

MFP Transition Coordination will be contracted services of DHS

DHS process is most appropriate for both population groups

-Address issues such as:

>Scope of services offered

>Quality of services offered

>Not being accepted for MFP Program

>Not being treated well by staff

>MFP program can deny payment for transfer if it is determined that it is not in the best interest of the person to move

>HCBS services can withdraw services if it is determined that recipient Cannot live safely on their own-this can be appealed

7. Benchmark One

- Projected Numbers for each population group was reviewed
- It was agreed to reduce 1st year bench mark from 25 to 15 persons to be transitioned out of Nursing facilities as the result of having only 6 months for transitions

-This adjustment will be accomplished by exchanging the 2010 benchmarks with the 2008 benchmarks for the populations of elderly persons and persons with a physical disability

- It was agreed that all four CILs would provided transition services as soon as the OP is approved-This is change from only the Grand Forks and Fargo CILs
- Referrals will come from NF staff
- Individuals referred will be challenging to serve
- No changes will be made to the number of transitions expected from ICF/MRs

8. Benchmark Two

- A report clarifying the expected increases in HCBS spending and deceases in Nursing Facility spending was reviewed.
- The budget prepared for the grant related to spending on HCBS spending was reviewed

-The budget will need to be recalculated as the result of the recommended change to the number of transitions to occur the first year of the grant
-Potential referral pool of current NF resident requesting transition will be secured for review
-Discharge planning is required of NF and will need to work with the transition team
-Pool will be limited by the current MFP protocol such as ADLs, cognition, medical condition etc.

Next Meeting Date: 12/19/2007, 1pm to 4pm, AARP Building, 107 West Main, Bismarck, ND
Linda Wurtz will make projector available
Bruce Murry will bring Laptop to use for meeting managment

ATTACHMENT 1

50-24.5-03. Powers and duties of county agency. Each county agency shall:

1. Administer aid to aged, blind, and disabled persons at the county level under the direction and supervision of the department, pursuant to state requirements.
2. Provide the services described in this chapter. The county agency may contract with a qualified service provider in the provision of those services.
3. Determine eligibility for benefits under this chapter and periodically redetermine eligibility of persons receiving benefits pursuant to this chapter.
4. Review the circumstances of congregate housing for residents receiving services under this chapter which may exist or may be established in the county and certify to the department that each congregate housing facility conforms to standards contained in rules adopted by the department.
5. Provide case management services to eligible beneficiaries.

50-01.2-03. Duties of county social service board. The county social service board of each county in this state shall:

1. Supervise and direct all human service activities conducted by the county including county general assistance or other public assistance.
2. Supervise and administer, under the direction and supervision of the department of human services, human services in the county which are financed in whole or in part with funds allocated or distributed by the department of human services.
3. Aid and assist in every reasonable way to efficiently coordinate and conduct human service activities within the county by private as well as public organizations.

50-06.2-04. Powers and duties of county agencies. Each county agency has the following powers and duties under this chapter:

1. To administer comprehensive human services programs for individuals and families at the county level in conformity with state and federal requirements under the direction and supervision of the state agency.

75-03-23-03. Eligibility determination - Authorization of services.

1. The department shall provide written notice to the county social service board of the county where the applicant receives services as of the effective date of the applicant's eligibility for services funded under the SPED program.

2. A person transferred to active status from the SPED program pool shall continue to meet the eligibility criteria of section 75-03-23-02 in order to remain eligible for services funded under the SPED program.

3. The county social service board's home and community-based services case manager is responsible for:

   a. Verifying that the person transferred to active status continues to meet the eligibility criteria for entry into the SPED program pool;

   b. Developing a care plan; and

   c. Authorizing covered services in accord with department policies and procedures.